

MALPRACTICE AND POSITIVE RESPONSE FORM

****Please complete a separate form for EACH occurrence for EACH question you answered positively. Please type or print legibly.**

Name _____
Last First Middle

License Number _____

Indicate the number of the question on your renewal application to which you answered "YES" _____

1. Describe in the space provided below or on a separate piece of paper the circumstances surrounding the positive response including patient outcomes if applicable. Be sure to include the date of the occurrence/incident. In the case of a malpractice action please include the amount paid on your behalf if any.

2. Provide the current status of the issue.

This information is to be **your** account of the occurrence. You may also submit copies of letters from you or your attorney, any court documents, etc. to supplement your account of the occurrence.

Signature: _____ Date: _____

Please mail to Professional Licensing Agency, Medical Group, 402 W Washington St., Room W072, Indianapolis, IN 46204.